Exhibit 49

UNITED STATES DISTRICT COURT

DISTRICT OF MASSACHUSETTS

NO. 01CV12257-PBS

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IN RE: PHARMACEUTICAL INDUSTRY AVERAGE)

WHOLESALE PRICE LITIGATION)

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THIS DOCUMENT RELATES TO:)

ALL ACTIONS)

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VIDEOTAPED DEPOSITION of MAUREEN CONEYS, called as a witness by and on behalf of the Defendant, pursuant to the Federal Rules of Civil Procedure, before Teresa E. Costello, Registered Professional Reporter, Certified Shorthand Reporter No. 1452S98, and Notary Public within and for the Commonwealth of Massachusetts, at the offices of Robins, Kaplan, Miller & Ciresi, 800 Boylston Street, Boston, Massachusetts, on Wednesday, April 12, 2006, commencing at 9:38 a.m.

MAUREEN CONEYS,
having been satisfactorily identified by the production of her driver's license, and duly sworn by the Notary Public, was examined and testified as follows to direct interrogatories:

BY MR. MANGI:

Q. Good morning, Miss Coneys. My name is Adeel Mangi as I just mentioned. I'll be asking you a few questions this morning. Have you ever been deposed before?

A. Yes, I have.

Q. How many times have you been deposed before?

A. Probably twice.

Q. Do you recall when those depositions were?

A. One was back in probably the early '80's, and another one was also probably in the '80's.

Q. What was the case in the early '80's about?

A. I don't remember.

Q. How about the one later in the '80's?

A. It was related to a malpractice case involving the Blue Cross health center.

Q. Do you recall where you were employed at the time of the first case in the early '80's?

A. I was employed by Bay State Health Care.

Q. Did the case relate to your employment at Bay State Health Care, the case in the early '80's?

A. I don't remember.

Q. Do you know whether or not it was a case that you were involved in personally, or was it a case that had something to do with your job?

A. It had something to do with my job.

Q. The second case later in the '80's, was it an allegation of malpractice against a physician employed by Bay State?

A. A physician employed by Blue Cross.

Q. And how did you come to be involved in that case?

A. I was the executive director for the health center where the physician practiced.

Q. It's been a while since your last deposition, so I'll just remind you to please answer

all questions audibly so the reporter can take them down, okay?

A. Okay.

Q. And I'd also ask you to wait until I finish a question before giving an answer so the record is clear, all right?

A. Yes.

Q. And if, at any time, you'd like to take a break, just let me know and we'll do that, okay?

A. Okay.

Q. Now are you currently employed by Blue Cross Blue Shield of Massachusetts?

A. Yes, I am.

Q. What is your title at present?

A. Senior vice president for healthcare quality and cost.

Q. How long have you held that position?

A. Since 2001.

Q. Have you held that position continuously from 2001 to the present?

A. Yes.

Q. I'd like to turn a bit further back in

time and ask you about your educational background. Can you describe for me, please, any qualifications you obtained after high school?

A. I have a diploma in nursing.

Q. When did you receive that qualification?

A. 1975.

Q. Did you receive that diploma directly after completely high school, or did you work for a while?

A. Directly after completing high school.

Q. After completing your diploma in nursing have you taken any further courses as part of a formal educational degree?

A. No.

Q. After completing your diploma what did you do next?

A. I worked at South Shore Hospital.

Q. What capacity did you work at South Shore Hospital?

A. I was a staff nurse.

Q. Did you have any particular area of specialty?

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was the member had insurance from Blue Cross Blue Shield, but also had other insurance.
Q. By other insurance, are you referring to more than one product from Blue Cross Blue Shield, or a BCBS product plus a product from some other health insurer?
A. A product from another health insurer.
Q. Can you provide an example of a situation where that might occur?
A. A husband and wife may both be employed and may both have health insurance that covers one another or covers the children.
Q. How did you come to start consulting for BCBS in 1988?
A. The president of Bay State that I had worked for had made some contact with the individual who was in charge of the Blue Cross health centers at that time, and he expressed an interest in hiring someone to work on some HMO type functions with the staff models, and that individual gave him my name.
Q. Now who was the person in charge of the BCBS health centers at that time?

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A. Ron Davey.
Q. Is that D-A-V-Y?
A. D-A-V-E-Y, I believe.
Q. Do you recall what Mr. Davey's title was at that time?
A. I don't.
Q. When you refer to the health centers, are you referring to the entire staff model HMO organization, or are you referring to some part of that organization?
A. I'm referring to some part of the organization.
Q. By health centers are you referring to hospitals, physician offices or both?
A. I'm referring to physicians' offices.
Q. Do you know how long Mr. Davey was in charge of the staff model HMO physician offices?
A. I don't remember exactly.
Q. Is Mr. Davey still with the company?
A. No.
Q. Do you know when he left the company?
A. It was in, I believe, 1990, early '90's,

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'91, '90 time frame.
Q. Was Mr. Davey the one who was responsible for bringing you on as a consultant?
A. Yes.
Q. In 1988 at the end of that seven-month period when you were consulting, what did you do next?
A. I was hired by Blue Cross Blue Shield as the executive director for the Medical East Community health center site in Braintree.
Q. Now when you refer to the community health center, was that a hospital or a physician office?
A. A physician office.
Q. How many physicians were employed at the community health center in Braintree?
A. About 25.
Q. Did those 25 doctors come from one area of practice, or were they cross specialties?
A. Cross specialties.
Q. Did they include rheumatologists?
A. Yes.
Q. Oncologists?

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A. No.
Q. Hematologists?
A. I don't remember hematologist.
Q. Do you recall what areas of specialty were represented?
A. There were internal medicine physicians with a variety of different sub specialties including rheumatology, and I don't remember the other sub specialties. There were pediatricians. There were surgeons and there were OB/GYN physicians. They were employed by the health center, and then there were other physicians that were brought into the health center under contract.
Q. When you referred to 25 doctors earlier, were you including the contracted physicians?
A. No.
Q. How many contracted physicians were there?
A. I don't remember exactly, but somewhere around probably six or seven.
Q. What was the distinction between the doctors who were employees versus contracted?
A. The employed physicians were actually

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employees of Blue Cross Blue Shield of Massachusetts and did not have practices outside of the health center.

The physicians who were contracted physicians were not employed by Blue Cross Blue Shield and had practices outside of the health center and then contracted with the health center to come into the building and see patients who were members of the staff model.

Q. Was there any particular reason for using both avenues to get physicians to treat members?

A. Many of the physicians that were under contract weren't needed on a full-time basis.

Q. Did the contract physicians include any oncologists?

A. No.

Q. You stated earlier that the community health center you were responsible for was part of Medical East, is that correct?

A. That's correct.

Q. What is Medical East?

A. Medical East was Blue Cross Blue Shield

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part of its staff model organization.

Q. There was also a medical West organization, correct?

A. That's correct.

Q. Did Medical East deal with the eastern part of the state and Medical West the western part of the state?

A. That's correct.

Q. Did Medical East and Medical West form one entity or were they separate groups?

A. It was one entity that was actually called Medical West. Then there were the two divisions, the East and the West.

Q. So the staff model HMO was called Medical West as a whole?

A. Yes.

Q. But Medical West actually had two parts, one of which was Medical West, but the other was Medical East?

A. That's correct.

Q. I wonder who thought of that. When you joined the BCBS of Massachusetts staff model HMO in

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1988, was it just getting started, or had it already been in existence for some time?

A. It had been in existence for some time.

Q. Do you know when that organization was created?

A. I don't remember exactly.

Q. Do you know whether it was in the late '80's, early '80's, '70's?

A. I don't remember.

Q. How many health centers did the staff model HMO consist of at the time you first joined it in 1988?

A. Medical East had a location in Braintree at New England Deaconess, Norwood, Peabody and Methuen, and then Medical West had three or four locations, I don't remember exactly.

Q. How long did you work for the staff model HMO organization?

A. Until 1991.

Q. By 1981 had the number of facilities increased, decreased or stayed the same?

MR. COCO: You said '81. Can you --

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MR. MANGI: Sorry.

Q. By 1991.

A. The number had decreased.

Q. To what extent had the number decreased by 1990?

A. The location at New England Deaconess was closed and, you know, I can't remember exactly. The Norwood location was also closed, but I don't remember whether that was -- it was right around the 1991 time frame. I can't remember whether it was some time after '91 or still -- or before.

Q. Are all of the facilities that you described earlier, the five for Medical East and the three or four for Medical West, were those all physicians' offices?

A. Yes.

Q. Did Medical East or Medical West also own any hospitals?

A. No.

Q. What happened when a patient who came for treatment to one of these staff model HMO physician office sites needed hospital treatment?

A. They would be referred to a hospital that the health center had a contract with.
Q. Did Medical East, Medical West own any retail pharmacies?
A. No.
Q. So if a physician needed a self-administered drug, it would be given a prescription and would fill it at an outside retail pharmacy?
A. The health centers did have pharmacies, but they were not the retail pharmacies. They were used solely for the members of the health plan.
Q. Where were those pharmacies housed?
A. Within the health centers.
Q. So if a patient went to a health center, got a prescription, he would then fill it at a pharmacy within the same facility?
A. That's correct.
Q. If a doctor needed to administer a drug to a patient in the course of an office visit, how would the doctor get the drug?
A. It would be supplied by the pharmacy.
Q. By the pharmacy, you're referring to the

same pharmacy within the facility owned by the staff model HMO?
A. That's correct, unless it was a drug that wasn't carried by that pharmacy and had to come from an outside source.
Q. We spoke earlier about the number of physicians employed at the Braintree site, around about 25 plus six or seven contracted doctors. Were all the health centers of approximately the same size?
A. No, the health centers in the East were smaller. Braintree was the largest health center in the East.
Q. What was the smallest health center in the East?
A. It was either Norwood or New England Deaconess.
Q. Approximately how many physicians were employed at those facilities?
A. Three or four.
Q. Now Braintree was the largest size for Medical East, but was Braintree still smaller than

all the sites at Medical West?
A. It was smaller than some of the sites in the West.
Q. What was the largest site in the West?
A. I believe it was the Chicopee location.
Q. Do you know how many physicians were employed at the Chicopee location?
A. I do not.
Q. Can you approximate the size of the Chicopee's facility relative to Braintree? Was it twice as big, three times as big?
A. It was at least twice as big.
Q. Your position as executive director for the Braintree site, how long did you hold that title?
A. Until 1991.
Q. Where did you move to in 1991?
A. I became, still within Blue Cross, the regional executive director for HMO Blue.
Q. After 1991 did you work directly at any sites owned by staff model HMO?
A. My office was not located in the staff

model any longer.
Q. But, of course, as the regional executive director for HMO you still dealt with the staff model HMO?
A. That's correct.
Q. We'll get to that in a minute. Let me state first with this '88 to '91 time period can you describe for me, please, the structure of the Braintree site?
I understand you were the executive director, and I understand there were 25 employed physicians, contract physicians. Who else worked at that site?
A. There was a medical director who was a physician who I worked closely with in terms of the clinical aspects of the practice. There were also administrative people in terms of finance, human resources, health center operations, you know, maintenance, those kinds of activities, and then there were a variety of medical disciplines including nurses, psychologists, social workers, physical therapists and then people who did, you

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Q. If the membership was lower than forecast, does that mean that fewer patients sought treatment at the Braintree site that was anticipated?
A. That's correct.
Q. Wouldn't that lead to the site having lower expenses versus higher expenses?
A. It had, you know, overhead that was the space and staff and so forth that it wasn't covered by the volume of members using the site.
Q. Well, how did the number of members that used the site affect the budget of the site or the amount of money that came to the site?
A. There were certain costs for the site that were fixed, so those costs were those costs. There were other costs that were determined based on a per member, you know, per month or per member per year basis, so it was a combination of both methodologies.
Q. Now when you say certain -- when you refer to the per member per month amounts, what are you referring to there?
A. There would be an assumption that for

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every member there would be a certain amount of hospital care utilized or, you know, office visit care utilized, prescription drug utilized.
Those kinds of things were determined on a per member, per month projection versus the cost of the building which was fixed and known in terms of the lease cost and operating costs of the building.
Q. Well, those were the two aspects that built up into the forecast, right?
MR. COCO: Objection.
A. Those were two of the factors.
Q. So there was one amount that was forecast in relation to the fixed expenses, and then there was another amount that was forecast in relation to the number of members who would receive treatment at that site?
A. Right.
MR. COCO: Objection.
Q. Now if fewer than the anticipated number of members sought treatment at the site, wouldn't that result in a lower expenditure by the site?
A. Yes, it would, but it would also result in

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lower revenue being attributed to the site because the revenue was determined based on the number of patients and members who chose the site as their site of care.
Q. That's the aspect of this I am trying to understand. How was revenue, number one, determined and then advanced and then calculated?
MR. COCO: Objection.
A. Revenue was determined based on the premium that the health plan collected from the members who selected the health center. There were also some fee for service patients that were seen. The health center did have a contract with the Medicaid program, so it did see some Medicaid members and received some revenue from Medicare as well.
Q. Those premium payments would be made to the central organization to BCBS of Massachusetts, right?
A. Correct.
Q. Would that revenue then be somehow transferred to the Braintree site or attributed to

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the Braintree site?
A. Attributed to the Braintree site.
Q. Now if the revenue that was attributed to the Braintree site was less than had been anticipated, in other words, if fewer patients chose the Braintree site than had been anticipated, would that affect the actuals number that was used in assessing the profitability of the site?
A. Yes.
Q. How would it affect that actuals number?
A. If there were -- if there was less revenue then there would be less, you know, revenue contributed to the overhead. The overhead didn't change, much of the overhead.
Q. So the actuals number was not comprised just of expenses. It was the difference between expenses and revenue attributed to the site, is that correct?
A. Yes.
MR. COCO: I'll insert an objection.
Q. In 1991 you became the regional executive director for HMO Blue, is that correct?

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A. Yes.
Q. What were the circumstances in which you moved from the Braintree site to the BCBS of Massachusetts organization?
A. The company had made a decision that it would take all of its existing HMO's, both staff model and IPA group models, and combine them into one HMO product and expand it to have a state-wide presence, so I was asked to take a role within the organization that was developing the HMO product.
Q. Was that product referred to as HMO Blue?
A. Yes.
Q. Can you describe in broad terms how HMO Blue was different from what had existed prior and how it functioned in the market?
A. Prior to HMO Blue, Blue Cross had a number of HMO's that were sort of, you know, they were sold as separate products and they were managed in different ways within the organization. With the development of HMO Blue the company had the desire to combine all of its HMO entities into one entity and one product and market it as one product and

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make that product state-wide. The HMO's prior to that did not provide state-wide coverage. There were gaps in coverage across the state.
Q. So let me see if I understand this. Prior to HMO Blue a member may sign up for a particular product whereby he would receive his treatment at the Medical East facilities, right?
A. Correct.
Q. Or he may sign up for another product and then he would get his treatment at physician practices outside of the staff model HMO?
A. Correct.
Q. After HMO Blue, how did things change from the perspective of the individual patient who signed onto that product?
A. The patient would sign onto HMO Blue and then would have the choice of physicians, either any physician who was part of HMO Blue which included the physicians who practiced at the health centers.
Q. Now HMO Blue is just the name of the product, correct?
A. Correct.

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Q. Did Medical East, Medical West remain in existence after the creation of HMO Blue?
A. They did for some time, but I don't remember exactly when they stopped existing as separate entities.
Q. Are you thinking of a time when a staff model HMO ceased to be a part of BCBS of Massachusetts, or are you thinking of a name change?
A. Both.
Q. Well, let's take them one by one. After you left the Braintree site, what is your understanding of the changes that took place in the structure and organization of the staff model HMO?
A. The staff model HMO continued to operate as -- I'm sorry -- discontinued to operate as a staff model. Eventually the physician practices that were owned by Blue Cross that were formally the health center practices or staff model practices were sold.
Q. Now when you refer to staff model stopped operating and health centers being sold, are you referring to one event one time period?

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A. I believe they happened in separate time periods.
Q. Well, what happened -- which came first?
A. The staff model stopped operating as a staff model.
Q. What happened in the interim time period between when it stopped operating as a staff model and when the staff centers were sold?
A. The physicians and staff of those health centers continued to be Blue Cross Blue Shield of Massachusetts employees, but there was not a product that was sold as a staff model HMO product, and the health center stopped using the name, Medical West -- I'm sorry, Medical East and Medical West, and the physicians adopted practice names.
The Braintree health center became known as the Braintree Medical Associates who were part of HMO Blue.
Q. Now during that interim period the physicians and other staff of the facilities were still full-time salaried employees of BCBS of Massachusetts, right?

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A. Strategies were developed to try to negotiate with the providers that were needed.
Q. What were those strategies?
A. I don't remember them specifically, but it was how the providers would be approached and who would approach them and, you know, what the alternatives were in the area if we couldn't get particular providers to join the network.
Q. Was any consideration given to providing additional amounts in reimbursement to incentivize participation in the network?
A. I don't recall any discussion about reimbursement.
Q. How long were you the executive director for HMO Blue?
A. Until 1996, I believe.
Q. What position did you move to in 1996?
A. I became the deputy director of Blue Cross Blue Shield of Massachusetts and New Hampshire, LLC.
Q. Let my pen catch up with that for a second. There's a lot packed into that title. Can you help me understand the various aspects of that?

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A. Yes. At that time Blue Cross of Massachusetts and Blue Cross of New Hampshire had a desire to work together to strengthen the regional presence in the Blue Cross plans, and there was a small group that was designated to work on what that would look like, and I was one of those people.
Q. Was a particular entity created called BCBS of Massachusetts and New Hampshire, LLC?
A. There was an LLC. The title was something like what I described.
Q. What were the parameters under which the two BCBS organizations wanted to work together?
A. Both plans would remain independent of one another, but would collaborate on various activities to improve our position in the marketplace or improve our efficiency as organizations.
Q. Did any aspect of that collaboration include the sharing of provider networks?
A. No.
Q. What sort of areas were encompassed by the collaborative work?
A. Some of the health management programs,

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whether there were any opportunities to collaborate on the administration of disease management and other health management programs, you know, purchasing kinds of discussions. I can't remember any of the other things we looked at.
Q. What do you mean when you refer to purchasing?
A. Supplies.
Q. Are you referring to gauzes, bandages, things like that?
A. It would actually be more office supplies.
Q. Did that include drugs?
A. No.
Q. How many people were involved in that collaborative effort?
A. Four.
Q. I take it one of them was the director?
A. Yes.
Q. And who were the two who worked below you?
A. There was another person who was at the same level I was, Alan Rosenberg, and then there was somebody who worked at the next level whose name was

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Sheila Buckley.
Q. Who was the person who was the director?
A. Sharon Smith.
Q. How long were you the deputy director of that entity?
A. About a year and a half.
Q. Did the collaborative effort continue beyond that?
A. No.
Q. So it lasted -- did it last in total for that year-and-a-half time period?
A. Right.
Q. What was the conclusion of that collaborative effort?
A. I don't know exactly what you mean.
Q. Were efforts at collaboration ended, or were they made part of a different process?
A. They were made part of a different process.
Q. And how was that change -- what was that change structure?
A. I don't remember exactly how it was

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structured.
Q. Was Ms. Smith the director of that effort throughout that time period?
A. For the year and a half, yes.
Q. In 1997, that ended in 1997, correct?
A. I believe it was 1997.
Q. Where did you -- what position did you move to then?
A. Vice president for government programs.
Q. How long did you hold that position?
A. Until 2001.
Q. 2001?
A. Ah-hah.
Q. What were the government programs that you were the vice president responsible for?
A. Responsible for the company's contract with the Medicaid program and with federal government for its Bluecare 65 product.
Q. Now what was the contract in relation to Medicaid?
A. The Medicaid contracts with health plans to enroll Medicaid recipients into their health

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plans. For some period of time Blue Cross was a contracting health plan to Medicaid.
Q. Now in those situations what amount was Medicaid paying to BCBS of Massachusetts in relation to Medicaid patients who had enrolled in its programs?
A. I don't remember the amount we were paid.
Q. How was it calculated?
A. It was calculated based on a formula that the state, you know, used, and I don't remember the details of the formula.
Q. Was it a capitated amount?
A. Yes.
Q. Were the Medicaid patients then enrolled in a specific BCBS of Massachusetts product, or did they have a choice of product?
A. They were enrolled in HMO Blue.
Q. Did the Medicaid patients have to pay premiums to BCBS Massachusetts?
A. No.
Q. So their entire payment was made by the Medicaid program to BCBS of Massachusetts?

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A. That's correct.
Q. Now the amounts that BCBS of Massachusetts then reimbursed physicians who treated those patients, were those the same amounts that were reimbursed to physicians who were treating any other HMO Blue patient?
A. I believe so.
Q. So BCBS Massachusetts did not reimburse providers at the same rate as Medicaid would have reimbursed them had the patient had direct Medicaid coverage?
A. Correct.
MR. COCO: Objection.
Q. Do you know what methodologies of Medicaid was used over time to reimburse providers in Massachusetts treating Medicaid patients?
A. No.
Q. Do you have an understanding what methodologies have been used at any time by Medicaid in Massachusetts?
A. I believe they pay fee for service.
Q. Do you know how the amounts in the fee for

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service schedule are calculated?
A. No, I do not.
Q. Or derived?
A. No.
Q. How long did BCBS Massachusetts have the Medicaid programs that we've been discussing?
A. For several years, but I don't remember the exact time line.
Q. Did the program start when you became VP for government programs, or did they already exist?
A. They already existed.
Q. Were the programs concluded, terminated during your tenure as the VP for government programs?
A. Yes.
Q. Some time in '97 to 2001?
A. Yes.
Q. Do you know when approximately?
A. I don't remember when.
Q. Now the BC65 product, that was a similar product on the Medicare side, correct?
A. It was a --

Exhibit 50

UNITED STATES DISTRICT COURT

DISTRICT OF MASSACHUSETTS

MDL Docket No. 01CV12257-PBS)

IN RE:)

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PHARMACEUTICAL INDUSTRY AVERAGE)

WHOLESALE PRICE LITIGATION)

VIDEOTAPED DEPOSITION OF JAMES E. FANALE, M.D.

Friday, June 9, 2006

9:08 a.m. to 3:27 p.m.

Robins, Kaplan, Miller & Ciresi LLP

800 Boylston Street

Boston, Massachusetts

Reporter: Lisa A. Moreira, RMR/CRR

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Shield," "BC/BS," I will be referring to the Massachusetts entity.
A. Okay.
Q. Dr. Fanale, is there any reason you can't testify truthfully and fully this morning?
A. No.
Q. Could you briefly describe for me your educational background since graduating from high school?
A. I attended college at the Pennsylvania State University. I received a bachelor's degree there. I went on to Chicago Medical School; received my M.D. there. I came to Massachusetts and trained in Worcester in an internal medicine residency program and received -- became board eligible upon completion of that training program and passed the board certifying exam after that.
That's the educational history.
Q. And when did you graduate from Chicago Medical School?
A. 1976.
Q. And what year was it you completed your

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residency and internship in --
A. 1979.
Q. Okay. Could you describe for me briefly your professional background since -- well, you've already done a bit, but since graduating from medical school.
A. And remember, some of these years are not going to be perfect.
Q. Fair enough. To the best of your recollection.
A. To the best of my recollection, I, upon completion of the residency program, chief residency in Worcester Memorial Hospital -- and it's undergone name changes over the years, but let's just leave it at Memorial in Worcester -- I began practicing internal medicine as an employed physician and had a number of administrative functions including running part of the training program for the residency program there, developing a geriatrics academic, clinical and research program for a number of years, went on to become involved in administrative leadership of the physician base group practice

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there for a number of years.
Then after some time there I moved on to Blue Cross to become, at the beginning of my career at Blue Cross, what was the title called senior vice president, provider partnerships, then moved on to the roll of chief medical officer.
I elected to leave there I think the end of 2003/2004 to become the chief medical officer at Mercy Hospital and subsequently become the chief operating officer at Mercy Hospital in Springfield, Mass.
Q. So after completing your residency and internship at Memorial Hospital, you began working there in roughly '79, I believe you said?
A. Uh-huh, yes.
Q. And how long did you work at that hospital?
A. From 1979 to sometime I would say -- actually, probably 1999 when I went to Blue Cross. There was a few months of doing both jobs, et cetera, but essentially that's the time frame.
Q. So you began working at Blue Cross/Blue

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Shield of Massachusetts roughly in '99?
A. I think it was in June of '99.
Q. And what was your initial position there again?
A. I was the senior vice president for provider partnerships.
Q. And at some point in time you said you became chief medical officer there?
A. Uh-huh, yes.
Q. What year was that?
A. I'd guess 2001, but that's my -- to the best of my memory.
Q. And then in roughly 2000 -- end of 2003/2004 you said you left Blue Cross/Blue Shield to go to Mercy Hospital?
A. Correct.
Q. And you're still there?
A. Yes.
Q. And initially you were the chief medical officer there?
A. Yes, at the system level, which is a large system with a behavioral health hospital, acute

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in this strategy, and the fact that really -- again, to my recollection, the first -- and I referred to the first category of drugs being the hemophilia factor, there wasn't much -- there was some discussion with some providers -- for instance, it could have been one of the Boston-based providers who had a hemophilia center -- in terms of ensuring that we didn't get in the way of their provision of care for these patients. And, in fact, to the best of my memory, there was one discussion -- it was either at Children's or the BI, and I really don't know which -- that had a significant issue with us doing this. If we couldn't work it out, we probably wouldn't do it if it was going to interfere with the care of the patients.

But we didn't get to the level of spending a lot of time with physicians when I was there because we didn't go into the -- we hadn't gotten to the point of contacting those providers who used the other drugs or the more commonly used drugs. So, for instance, we hadn't gone to talk to the oncologists yet, because that wasn't -- that wasn't

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on the list to go to at that point in time.

So really, it was a limited provider discussion because we were only doing -- like I said, the first round was hemophilia. And I'm sure if we go through this there may have been another one that will come up in my memory that we looked at. But to the best of my knowledge, the first one was like the hemophilia-clotting factor.

And also, probably we looked at -- but my memory -- but we couldn't really exact much of a savings, was on the enzyme deficiency drugs; you know, for Gaucher's disease and those things. Remember, you have two or three members who get those drugs, and they're very highly specific, and you don't have a lot of leverage in negotiating price since there is only one drug. Okay?

So those are the kinds of levels of drugs we looked at when I was there.

Q. And that drug you were just referring to where you said you probably couldn't realize much of a price savings or discount, is that because you wouldn't be buying the types of volume you might be

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on some of the other drugs?

A. Yes, because it's a single-source drug, meaning only one place makes it. It's a very small number of patients, thankfully, that need it, and they have to have it, so the utilization has to be there.

The only way you'd extract a price reduction on that is if you have a supplier that sells all bunches of other stuff, and you decide to buy a whole bunch of stuff from them, that you might be able to exact a price decrease for that drug, but that's why.

Q. Do you know -- well, let's take, for example, oncologists and some of the chemotherapy drugs that would be administered in their office.

Do you know when they purchase these drugs directly and administer them in their offices, are they making a profit off of the purchase and the subsequent reimbursement of these drugs?

A. Let me sort of answer that with the amount of information I have. It is -- you know, from my experience, which I'll talk about, and also from the

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last couple of years when you've looked at reimbursement for this, there's been, again, some publications and some things in the press about oncologists concerned about Medicare controlling the costs of these drugs in their offices to the extent they now have -- they've increased reimbursement for the administration of those drugs by nurses in their offices to try to offset any potential loss they may have.

So in a roundabout way, it's fairly common knowledge. I think they're out in the field that on some drugs they're able to probably extract a profit off of administrating the drugs -- administering the drugs in their offices. It's common knowledge, I think, through -- if you look at the AMA news and other things, there's been a lot of discussion about this. If Medicare wants to control the price of oncologic drugs in the office, will physicians still want to deliver them in their office? And they can't continue to run their practices without that profit center, if you will; therefore, Medicare increased the payment for the administration of

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those types of drugs to help offset the costs involved in delivering those drugs in offices.
So with that, and with some knowledge I have from Blue Cross, it's pretty understood, there must be some financial benefit, the extent of which I can't say, to administering drugs in the office.
The other knowledge that I have about this is that it's like most things. Some drugs you could probably earn more of a profit off than others in terms of oncologists. But exactly the level of that gain, I'm sure we'll talk a little bit more about it, but I -- the knowledge I have is focused and limited.
Q. And as you said, it's not a controversial proposition --
A. Right.
Q. -- that these doctors, you know, wouldn't be administering these drugs if they weren't realizing some type of profit, whatever level that is, correct?
A. Or that the costs of delivering the service were at least reimbursed. You know, you

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could look at it both ways. One is, I'm not going to do it at a loss; I will do it as a profit. So those are the arguments out there.
You know, the oncologist will say, "I can't afford to give them if you don't allow me this potential profit"; and Medicare's saying, "Okay. Well, we'll increase the price of administering the drug's costs -- reimburse you for administering the drugs, and -- as we decide whether we're going to limit the potential profit." So it's both sides of that coin.
Q. So it's fair to say that in the past the actual reimbursement that these physicians were receiving for the administration of these drugs in their offices was not sufficient to cover their costs?
MR. HARRINGTON: Object to the form. Go ahead.
A. Would you ask it again?
Q. Sure.
MR. DUFFY: Could you read the question back.

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Q. Let me know if you don't understand it. I'll rephrase it.
A. I just want to hear it again. That's all.
(Question read)
Q. Let me clarify that.
A. Yes.
Q. When I'm saying the reimbursement they're receiving, I'm specifically talking specifically for the administration -- not the overall reimbursement, but specifically for the administration of the drug in the office setting.
A. That's why I wanted it clarified.
That's what they say, okay? Based on oncologic practice where, you know, you have to have nurses, you have to have a pharmaceutical hood and those kinds of materials to administer the -- I don't have any reason to say they're wrong, but I don't have anything that would say -- tell me, here's what it really costs, here's what -- so it makes sense to me, but I couldn't validate whether, in fact, that statement's true or not.
Q. Okay. And the general understanding,

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then, is, if, you know, they are not being reimbursed sufficient amounts specifically for the administration of the drug to cover their administration costs, that they're covering that on the other side from the profit they're making from the purchase for the drug itself?
A. That's the content --
MR. HARRINGTON: Object to form.
A. That's the contention.
Q. Do you have any reason to object to that contention or disagree with it?
A. I don't have any reason to agree or disagree. You know, I'd rather be able to look at it and see, in fact, what I believe, and what I don't believe. The question then becomes, is it a balance, is it -- is it that they make more profit than the cost, and how much is that profit? Again, you know, it's in the eyes of the beholder. But I've never looked at it, so I couldn't say.
Q. So that's an issue that you never looked at when you were at Blue Cross/Blue Shield?
A. Never was -- never had the ability to look

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you get. The physicians in this marketplace frequently complain that Medicare rates are too low, and, you know, the commercial insurers usually pay more than Medicare.

When I was at Blue Cross, early on in that tenure we were at the Medicare fee schedule for physician services. We were frequently criticized for being too low. Historically there were some Medicare rates in terms -- I'll take the proceduralist versus the nonproceduralist argument. You know, years ago Medicare used to pay a heck of a lot more for cataract surgeries then than it does now, so some of us that didn't do those kind of things thought that Medicare overpaid for certain services.

So in aggregate, I'd say the general feel on the street is Medicare is probably a bit too low. The commercials are -- commercial insurance companies are thought to have to be higher to make up for that. But it depends upon who you speak with. If you speak with the physicians, it's too low.

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The last time somebody asked you if your rates were too high, did you say no? You don't have to answer that.

That's like compensation. Do you get paid enough? People always want to get paid more. But I think the general understanding is they're probably a bit on the low side, Medicare. And the commercial insurance payments are different state to state, plan to plan. So Blue Cross in Massachusetts rates may be 10 percent higher than Medicare, whereas in Tennessee they could be 20 percent higher. So it depends upon the region you're in.

Q. How about your views on Blue Cross/Blue Shield's reimbursement rates for physicians?

A. At the time I was there? Now?

Q. Yes, at the time you were there.

A. I thought that we needed to have a strategy to increase the rates to demonstrate that we listened and valued what our physicians were saying. I thought that our rates needed to be competitive with our marketplace, Medicare being one of the players, but I wanted to make sure that we

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were at least at or a bit above our two principal competitors at that time being Tufts and Harvard.

Now, fee schedules notwithstanding, it's hard to compare one fee schedule to the next unless you have the same reimbursement floor in terms of all codes, if you will. So our strategy was that we were -- when I was there it was, we were at Medicare, and the strategy was moving that we would be higher than Medicare, with the goal being at least competitive with our two principal competitors in the commercial market here or a bit above.

So at that time I thought we were a bit low, and we needed to get there, and we did over time.

Q. Do you know approximately how much higher Blue Cross/Blue Shield's reimbursement rates were than Medicare's?

MR. HARRINGTON: Physician services?

MR. DUFFY: Generally for physician services.

THE WITNESS: Now, I have to ask the question, is -- and I don't know the answer to this,

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so... Seeing that this is a corporate issue, and it's corporate -- I mean, it's a corporate secret -- I mean, it's not publicly acknowledged, I don't know what I can say at that time and what's legitimate for me to say.

MR. HARRINGTON: I think you can give a general general answer with the understanding that the transcript's been deemed confidential.

THE WITNESS: Okay. All right. That's fine.

MR. DUFFY: Just for your information, there's a protective order in place.

THE WITNESS: Okay. I just -- that's what -- I just wanted to make sure.

A. At the time when I was at Blue Cross, the Medicare fee schedule and Blue Cross's were pretty similar, but by the time I left there in '03 it was probably a few percentage points above Medicare, so maybe the factor was 1.03 or so. I couldn't tell you exactly how we stacked up against our competitors, but on some fees we were the same, some we were lower, some we were higher. But on the

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A. Yes. I don't want to say what I said before. That is one of the stupidest questions I've ever heard, but -- I don't want to insult you, but, of course, everybody monitors.
Q. Okay. And what efforts do they undertake to monitor their competitive position?
A. Well, certainly you monitor whatever information you have available to you. You know what your size is. You try to hear what your brokers are out there selling and what they're hearing. Whatever competitive intelligence you can get legally. You know what I mean?
You can't -- you know, if -- with the RBRVS system, if Blue Cross publishes its conversion factor, and Harvard Pilgrim publishes a conversion factor, and they stayed purely to the RBRVS system, you can tell what Harvard Pilgrim's paying. The problem is, do they have different conversion factors per physician group? That's when it changes.
But if generically you have one fee schedule, use RBRVS, and you have a conversion

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factor, anybody -- any competitor of Blue Cross's now can tell us what our fee schedule is, can tell Blue -- can tell what Blue Cross's fee schedule is. Just by knowing the conversion factor, you know what the fees are, assuming there's one conversion factor.
So competitive intelligence being what it is, you can get some of that just by deduction.
Q. So is it typically the case that these different private health insurers publish their conversion rates, or it's publicly available information?
A. Blue Cross's position was to publicly -- well, Blue Cross's position was to send a letter out to its providers telling what his conversion factor was, and the provider could read and figure out -- look at the codes, they could figure out what the fee schedule was.
It wasn't that it wasn't -- they didn't put in the newspaper, but it was readily obtainable. It wasn't private.
Q. But aside from that publicly available

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conversion factor, I understand from your testimony there might have been more closely held different conversion factors for different provider networks or groups?
A. For Blue Cross there was one conversion factor and held firmly to one -- at that time one fee schedule for all providers. There was some -- and when Harvard Pilgrim would publish their fee schedule, there was a lot of consternation and concern that they probably had more than one conversion factor; that, in fact, it wasn't the same as Blue Cross. So that's what our competitive intelligence told us.
Q. And in monitoring its competitive position with respect to the other health insurers, is the reimbursement rates that it provided to providers something that Blue Cross/Blue Shield looked at?
A. You couldn't really obtain that. I mean, that's private information. I mean, you could have some guesstimate from what someone told you, but it's all hearsay. There's no way you could obtain that documentation legally. In other words, no one

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-- we didn't know what every other hospital got paid from another health plan.
Now, you may go negotiate with a hospital, and they'd say, "Tufts is paying us $1,000 for this procedure," and you'd sit there and go, "Okay, I don't believe anything you're telling me because you're saying that so I'll give you more."
So you really couldn't obtain pricing from other health plans.
Q. So that was typically not readily available information?
A. No, it's not. No, it's not.
Q. Do you know, from your experience at Blue Cross/Blue Shield, did it ever try to -- you or others at Blue Cross/Blue Shield try to obtain information about the acquisition costs of physicians --
A. Acquisition costs.
Q. -- with respect to physician-administered drugs?
A. You know, did we -- no, I mean -- I'm trying to remember what I can tell you about this.

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I mean, first off, there was no process, plan, strategy, program to try to investigate exactly what people were getting paid, what physicians were getting paid for physician-administered drugs. It was commonly understood that some of the -- some drugs in physician's offices could be paid at X percent below AWP, maybe 40 or 50 percent, where some of the newer drugs they may be paying 100 percent of AWP, so --

THE COURT REPORTER: They may be paying 100 percent over what?

THE WITNESS: They may be paying 100 percent of AWP --

THE COURT REPORTER: Oh.

THE WITNESS: -- for their drugs.

A. They may be paying 40 percent for some drugs. There was -- and this was not just for Blue Cross, but if you got into some of the medical literature and the AMA News and that stuff, you could hear about the range of costs of drugs in offices. We did not have a concerted effort to find out what they were.

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I remember early on in my experience there that we met with one oncology group that complained about the 95 percent AWP, and I was pretty green when I went down there and sort of made an effort to say, "Gee, you guys are cutting my costs, and you can't continue to do this."

I got back and -- then we had discussion that -- you know, again, it was early on in my career there, not really knowing what was going on, but there was a range which was explained to me. There was a range in costs of drugs in physicians offices, but I didn't -- you know, as far as specific costs for a specific practice, no.

Q. But it was fairly well known, like you said generally, the range of costs that these physicians were obtaining these drugs at with respect to percentage discounts off of AWP?

A. See, the --

MR. HARRINGTON: Objection. Go ahead.

A. See, the problem with that is -- so if they -- you know, the problem with really knowing the truth about that is, so Dr. X could administer a

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protocol of three different drugs that maybe had a range of costs of 60 percent to 95 percent to 105 percent, and then another patient it may be all at 100 percent.

So not knowing specifically what the particular utilization of a percentage of drugs they used, there's no way to know that. You know, what's their mix of patients? What kinds of tumors are they treating? What kinds of new drugs are they using when they had to pay 100 percent versus 40 percent?

I expect they're doing okay, but I can't -- I don't know specifically.

Q. So it's correct to say, though, that in setting the reimbursement rates and fee schedules, that the acquisition costs of the physicians for these physician-administered drugs were not taken into account?

A. No, it's -- you know, I can't -- you know, I'm trying to figure out how to answer your question as precisely as I can, but the 95 percent AWP followed Medicare. As far as programs in the future

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to try, to modulate the cost of those, there would be no information in hand to make that decision. So I'm not saying they ignored it, but it hadn't gotten to the next level of doing that.

Q. Dr. Fanale, I'd like to ask you some questions about some e-mails that have been produced by Blue Cross/Blue Shield that you are either sent or received or were cc'd on.

MR. DUFFY: And I'm marking as Exhibit Fanale 008 a copy of an e-mail chain that was produced by Blue Cross/Blue Shield that's Bates-stamped 0048 through 0051. I'm going to ask you a series of questions about different portions of the e-mail. If you want to take some time to take a look at it, that's fine.

(Exhibit Fanale 008, BCBSMA-AWP-00048 through BCBSMA-AWP-00051, marked for identification)

Q. And these e-mails concern an issue that came up with Dr. Kagan with MASCO, which is Massachusetts Society of -- Oncologist Society; is that correct?

A. I think it's the Massachusetts Society of